MULTISYSTEMIC THERAPY
IMPLEMENTATION IN WASHINGTON[1]

PROGRAM AUTHORS

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GOALS OF MULTISYSTEMIC THERAPY

The goals of Multisystemic Therapy are to reduce problem behaviors, including crimes and substance abuse, at costs below those of incarceration or out-of-home placement. The therapy was developed to deal with youth and families for whom interventions were typically unsuccessful and who were at increased risk of out-of-home placement.

As discussed in *Blueprints for Violence Prevention: Book Six, Multisystemic Therapy*

> A crucial aspect of MST is its emphasis on promoting behavior change in the youth's natural environment. As such, the overriding goal of MST is to empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems.

TARGETED YOUTH

Multisystemic Therapy has been shown to be successful with high risk youth-those at risk of out-of-home placement. While the intervention is also successful with youth at lower risk levels, the intensity and cost of the intervention makes it most appropriate for youth at the highest levels of risk, including serious, chronic, violent juvenile offenders.

Referral to the program will be linked to the Risk Assessment instrument implemented by the courts under CJAA requirements.

EVIDENCE OF SUCCESS

MST has been demonstrated to reduce recidivism and other problem behaviors in juvenile offenders. In addition to evidence obtained from controlled studies, MST has been duplicated in several settings and continues to show effectiveness. The results are not affected by race/ethnicity, age and gender. MST is adaptable to cultural differences and developmental levels.

Data from continuing research on MST, including information on specific methods of implementation, will be incorporated in Washington. For example, weekly consultation with MST staff to maintain

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[1] These implementation guidelines were developed in collaboration with Keller Strother, MST, Inc. Portions were taken directly from materials provided by him, and other sections relied on *Blueprints for Violence Prevention: Book Six, Multisystemic Therapy*, produced by the center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado, Boulder, of which Scott Henggeler was principal author.

program integrity and consistent application of MST principles has been shown to be an important element in achieving targeted outcomes.

DESCRIPTION OF PROGRAM

MST is an intervention that works with youth and parents in their homes and in community settings. It removes barriers to access by taking the intervention into the community. Therapists work collaboratively with the family as a resource to recognize strengths and use those strengths to achieve behavior change. MST integrates known links between risk and protective factors and juvenile delinquency and other problem behaviors.

The therapist selected matches the family as much as possible to overcome cultural and other barriers to success. The team should reflect the ethnic make-up of the population being served. This helps establish closer links with the family and brings multiple perspectives to the therapy team.

Systems Approach

Consistent with focus on risk and protective factors, MST incorporates an ecological model in the intervention which assumes that behavior is an interchange between the individual and systems-the family, peers, school, work, the community. These become the framework for the intervention.

Problems are targeted for change and strengths are used to promote that change. Parents are given skills and opportunities to practice strategies to promote desired outcomes, such as better school performance or reduction in undesirable peer associations.

MST Treatment Principles

Nine treatment principles guide the intervention. Those principles are *(Blueprint):*

1. *The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context.* (Problems are identified in terms of "what makes sense"-What factors contribute to the problem and within or between which systems? These are the targets for intervention and are subject to continuous reassessment-is this working and how do we know it?)

2. *Therapeutic contacts emphasize the positive and use systemic strengths as levers for change.*

3. *Interventions are designed to promote responsible behavior and decrease irresponsible behavior among family members.*

4. *Interventions are present-focused and action-oriented, targeting specific and well-defined problems.* (Clear tasks and goals are established so the family and therapist can easily identify outcomes and progress. The focus is on taking actions that work, not on gaining insight.)

5. *Interventions target sequences of behavior within and between multiple systems that maintain identified problems.*

6. *Interventions are developmentally appropriate and fit the developmental needs of the youth.*

7. *Interventions are designed to require daily or weekly effort by family members.* (The frequent effort is more likely to promote a change in families, offers a way to measure progress or non-adherence, and gives more frequent opportunity to experience success.)

8. *Intervention effectiveness is evaluated continuously from multiple perspectives, with providers assuming accountability for overcoming barriers to successful outcomes.* This includes parent's assessment of adherence to treatment goals. One of the research findings is that this parental assessment is positively correlated with desired program outcomes.)

9. *Interventions are designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.* (Generalization of positive changes and long-term gains is the primary focus of MST treatment One research project has followed youth up to four years post-treatment with 72 percent having remained arrest-free.)

Target of Intervention-Youth and Parents

Parental involvement is critical. Part of the MST is to empower the parent to act in more positive and effective ways. The parent can be any adult who has primary responsibility and a guardianship role for the youth.) The parent is co-author of goals of the intervention-from the very beginning the therapist and parent are working to achieve an outcome they defined together.

One of the most frequently voiced problems by juvenile courts in Washington is that parents are not willing to participate, that they do not show up for appointments, and that they do not appear to care about their children. MST has demonstrated a very high rate of retention of families—as high as 98 percent in recent studies.

The high rate of retention is likely due to several factors: therapists work with families in settings and times convenient for the family; therapists are on-call 24 hours a day to respond to crises; the team of therapists take responsibility for engaging families and reaching outcomes-the team finds ways to keep the family involved; the intervention is focused on strengths and mutually established goals; and, the intervention is adapted to changing circumstances and progress during the intervention.

OUTCOMES

Multisystemic Therapy is outcome-focused, during and after the intervention. The goal set cooperatively by the parent and therapist at the beginning is linked to the behavior that brought the youth into therapy in the first place. Once the goal has been achieved, the intervention is complete. Intermediate goals and objectives are set along the way, achieved or examined and modified. The focus is continuously on doing what works and defining that in observable ways.

Outcomes expected after the intervention are that problem behaviors will be reduced, including recidivism, and that this will be accomplished at a cost lower than that associated with out-of-home placement.

BARRIERS

MST staff visit each site prior to training to work with agencies, administration, and others to identify and minimize barriers and lay the groundwork for success. However, several potential barriers exist, both from the experience of MST and those who have implemented the project. Some of those noted include:

- Lack of support from key agency stakeholders, such as social welfare, mental health, the schools, and family court.

- The ideal home-base for MST is an agency that provides supportive services for families. Since the alliance is with the family, settings that are traditionally punitive in orientation may detract from that feeling of alliance and confidentiality.

- From a replication in Galveston, Texas: An inadequate number of initial referrals raised concerns about therapists being able to practice skills. Coordination between probation and therapists (mental health) was an issue in the beginning, both because of court-ordered services and maintaining confidentiality; cooperative relationships were established. The project was jointly administered with partner agencies that led to initial confusion about roles and responsibilities.

- From a replication in Memphis, Tennessee: Funding was a problem initially until the project demonstrated success; the length of treatment was also a problem due to reimbursement policies that hindered the extended and flexible intervention required by MST. Another problem was having to overcome the mindset of some of the therapists who were used to a different way of doing business.

  Finally recruiting and training staff was a problem when they expanded to nearly 50 therapists in less than a year. MST consultants provided a special supervision training in 1997 to help the site become self-sustaining.

The direct involvement of the Juvenile Courts is positive factor for the State of Washington. Lack of court involvement was as a barrier in some of the replications.

STAFFING FOR MULTISYSTEMIC THERAPY

Multisystemic Therapy is delivered by one or more teams of therapists at a given site. Teams consist of from two to four therapists and a clinical supervisor.

Staffing Considerations

MST staff can be hired directly by the court, be secured by contract with another agency or provider (such as a mental health organization), or a combination of the two. Collaboration between agencies jointly funding an MST program is common.

There are several important staff requirements:

- Staff must be available 24 hours a day. A rotating call schedule allows response in a crisis, even when the particular therapist assigned to the case is not available. Staff must be familiar with all cases in order to provide this flexibility in response.

- Courts (and contracting agencies) must allow flexible staff reporting time to allow therapists to work with families at times and locations convenient for the families.

- Courts (or contracting agencies) must provide cell phones and transportation allowances (or arrangements) for therapists.

- MST therapists must be full-time employees whose time is exclusively devoted to MST. The clinical supervisor may have responsibilities outside of MST.

- Master's level therapists are strongly recommended. They are preferred because they have both the training and a demonstrated commitment. MST requires persistence. Highly trained bachelor's level therapists may be considered.

- A Ph.D. level clinical supervisor is recommended, although not required. The supervisor must devote at least 25 percent of his/her time to supervision; 50 percent is recommended.

- Therapist teams may be regional, if distance and transportation are not barriers. Therapists must be close enough to cover cases and consult with one another in person on a regular basis.

- Courts should also budget one hour of support-staff time per week for each therapist in the team. The support staff will interview families on a rotating basis so that each family is interviewed monthly. The interview is part of the quality assurance procedure that provides essential information on parental impressions of the sessions. The interview is conducted by phone and includes questions on accomplishments, relationship with the therapist, agreement on goals, assignments, and other factors pertaining to the last therapy session.

Caseloads

Each therapist will have an average caseload of four to six families at a given time. Actual time spent with the family will vary with each case The therapist may visit the family several times a week, on weekends, and during the evening depending on the needs of the family.

The following explanation of frequency and duration of client contact is taken from the *Blueprint:*

> The frequency and duration of sessions is determined by family need. Thus, sessions are held as often as every day early in treatment or when clinical progress is not being made. During the middle of treatment, the therapist may hold two to three sessions per week and call several times. As treatment termination nears, sessions may be held as infrequently as once a week. In addition, efficient use of therapist time is emphasized, with sessions ranging in length from 15 to 75 minutes. Thus, MST interventions have the flexibility to be relatively intense, in terms of both time in treatment (e.g., multiple sessions per week) and task orientation of treatment sessions (e.g., explicit goal setting and extensive homework assignments).

Significant additional time is spent in preparation, coordination with team members, working within MST systems to ensure adherence to guidelines and program integrity, and working with MST consultants (preparing case notes and weekly conference calls).

MST is delivered over a relatively short period of three to five months. Assuming the middle of the ranges (four months per case and five cases at a given time), a therapist should be able to work with approximately 15 cases per year.

TRAINING

MST training readies both the site and staff for success in implementing MST. The therapist will participate in training designed and delivered by MST consulting staff. Initial training consists of an intensive five-day orientation. Ongoing training consists of quarterly "boosters" and weekly team and supervisor consultation. Adherence to MST reporting formats further ensures integrity of program delivery at each site and across the implementation sites.

Program Development and Initial Training

Several activities occur to prepare sites to deliver Multisystemic Therapy. The process includes site assessment and preparation, tracking systems development, and initial orientation training.

- Pre-training Assessment and Assistance: The pre-training assessment takes a look at what is in place at the site-both assets and barriers. Like the MST intervention with the youth and family, the assessment is an individualized, pragmatic analysis of how MST can be most effectively implemented at the particular site. The intent is to remove barriers, involve necessary players, and elicit support from the community, agencies, administration, and others who can help make MST work smoothly.

  Prior to MST training, a consultant will provide up to two days of consultation regarding the development and implementation of a successful MST program. The objectives of the pre-training assessment are to identify the mission, policies, and practices of the customer organizations and of the community context in which it operates, and to specify the clinical, organizational, fiscal and community resources needed to successfully implement MST.

  These assessment activities include: on-site meetings with the organization's leadership and clinical staff, and meetings with staff from agencies that influence patterns of referral, reimbursement, and/or policy affecting the customer organization's capacity to implement MST. In addition, assistance is provided in designing clinical record keeping to document MST treatment goals and progress; measuring outcomes; reviewing evaluation proposals; and, consulting on requests for proposals (RFPs) relevant to the development and funding of an MST program.

- Five-Day Orientation Training: Five days of on-site training are provided for all clinical staff who will engage in treatment and/or clinical supervision of MST cases (e.g., psychiatrists, psychologists, counselors with whom the customer organization contracts for services).

  The initial training includes didactic and experiential components. Didactic components include:
  (a) instruction in systems theories, social learning theory, and the major psychological and sociological models and research regarding serious emotional disturbance in youth;
  (b) research relevant to problems experienced by targeted youth (e.g., learning disabilities, substance abuse); and,
  (c) research on interventions used in MST (e.g., empirically validated family and marital therapy approaches, parenting behavioral training, cognitive behavior therapy, school consultation).

Experiential components include role-plays on engagement, assessment, and intervention strategies, and exercises designed to stimulate critical thinking about the treatment process (e.g., what evidence therapists use to draw conclusions about the correlates/causes of a problem, to determine whether their interventions are effective, etc.)

- Tracking Treatment Fidelity/Adherence: MST consultants orient clinical supervisors to the process of periodic reviews of clinician adherence to MST. Such reviews may entail parent rating of adherence with measures developed in clinical trials of MST and accompanying clinicians in the field.

Cost of Program Development and Initial Training

The estimated costs shown below are per implementation site (county or organization) for up to four intervention teams (each team consists of two to four therapists plus a supervisor).

- Fees: $7,500 per implementation site (county or organization)
- Travel and expenses: $7,700 (estimated)

Ongoing Training and Consultation

Ongoing training and consultation consists of quarterly booster training conducted at the implementing site and weekly consultation by phone.

- Weekly Telephone Clinical Consultation: The core of the MST training program is the weekly telephone clinical consultation. One hour of phone time per week is dedicated to consultation for each team of two to four clinicians and their clinical supervisor. Teams fax weekly MST case summaries to MST consultants prior to the scheduled consultation time.

  The overarching objective of weekly telephone consultation is to facilitate clinician and clinical supervisor adherence to MST. Whereas the customer organization's clinical supervisor and MST team are responsible for day-to-day decision making regarding case particulars, the MST consultant is responsible for contributing to the rapid and sustained development of the clinician's ability to bring MST-like thinking and interventions to the case in question. In so doing, the MST consultant identifies obstacles to implementation of MST and suggests strategies to address these issues.

  When the obstacles appear related to the clinician, team, clinical supervisor, and/or consultant, recommendations can be made during telephone consultation. When the obstacles are related to organizational, community, fiscal, and/or policy issues, the MST consultant signals these possibilities to the appropriate audience (e.g., clinical supervisor, administrator, leadership of provider organization, state official contracting with provider) and assists the organization in developing strategies to overcome these obstacles.

- Quarterly Booster Trainings: As therapists gain field experience with MST, quarterly booster sessions are conducted on site. The purpose of these 11/2 day boosters is to provide additional training in areas identified by therapists (e.g., marital interventions, treatment of parental depression in the context of MST) and to facilitate in-depth examination, enactment, and problem-solving of particularly difficult cases.

Costs of Ongoing Training and Consultation

The estimated costs shown below are per implementation site (county or organization) for up to four intervention teams.

- Fees; $1,500 per MST team, per month (teams of 2 to 4 therapists)
- Travel and expenses: $2,300 (estimated) per quarter per implementing site

Orientation for Replacement Staff

Staff hired after initial training has occurred can receive the initial five-day orientation training that is offered periodically in Charleston, South Carolina. After completing the orientation training, new staff will participate in regular booster training sessions and weekly consultation with MST consultants.

Cost of Orientation for Replacement Staff

While costs for initial training for therapists are included in pre-implementation allocations for the courts, training replacement staff will be an ongoing expense that should be anticipated as a regular program cost.

- Fee for 5-day training: $750
- Travel and expenses: $2,700 (estimated)

START-UP AND ONGOING COSTS

In addition to staffing and training expenses, courts should anticipate additional equipment costs. Those are:

Start-Up Requirements

- Speaker phone for conference calls
- Fax
- At least one tape recorder which uses standard size cassettes
- Computer (word processing; access to the internet)

Estimated Start-Up Costs

- Computer: $2,000 (estimate)
- Other equipment: $1,000 (estimate)

Ongoing Requirements

- Mileage for therapist travel to appointments with families Long distance phone for conference calls and fax

Estimated Ongoing Costs

- Mileage: $3,450 per therapist (50 miles per day x 230 days per year x $.30)
- Long Distance Phone: $1,000 (estimate)

COLLABORATION

Referral and Coordination

Support of key agencies in the community is important for success. The site assessment visit by MST staff helps set the stage for good working relationships prior to implementation. The MST process itself fosters good relationships with agencies, some of which may have virtually given up on these youth. The therapist works with parents and youth to achieve desired goals in the natural settings—school, community, and work. Achieving those goals requires establishing working relationships, and the same process of mutual goal setting.

Staffing and Funding Collaboration

Multisystemic Therapy is commonly implemented by more than one collaborating agency. For example[1] MST was conducted in two counties in Ohio and struggled with funding early on, and then found considerable support under the statewide "Reclaim Ohio" program. This requires collaboration at the highest levels of departments responsible for youth and provides a significant financial incentive to counties that support effective programs to reduce out-of-home placement.

Regional Collaboration

Regional support of an MST team is possible, provided the courts are in close enough in proximity to allow clinical supervision and MST coordination.